DIALYSIS CLINICS

Dialysis services include those services and procedures designed to promote and maintain the functioning of the kidney and related organs.

Limitations

Hemodialysis or peritoneal dialysis services are limited to recipients who have a diagnosis of chronic renal failure [End Stage Renal Disease (ESRD)]. Reimbursement will be made to any Medicare Certified Dialysis Facility (Hospital or Freestanding) enrolled in the Medicaid Dialysis Program. Providers will be reimbursed for the physician or facility services rendered in an inpatient or outpatient hospital or in a freestanding dialysis clinic setting. Coverage of eligible ESRD recipients is limited to:

1. Services rendered by providers enrolled in the dialysis program;

2. Recipients enrolled in the program;

3. Recipients not eligible for Medicare, and

4. Services provided during the ninety (90) day waiting period required for Medicare eligibility determination.

Non-Covered Services

Non-covered services in this program include:

1. Services provided to Medicare-eligible recipients;

2. Services provided for acute renal failure;

3. Services not listed as separately billable in the policy manual;

4. Experimental services or procedures or those which are not recognized by the profession, the Department or the United States Public Health Service as universally accepted treatment; and

5. Services provided to recipients not enrolled in this program.

TRANSMITTAL 89-34
APPROVED 4-19-90
EFFECTIVE 10-1-89
SUPERSEDES (NEW)

9. CLINIC SERVICES CONTINUED

AMBULATORY SURGICAL CENTER SERVICES (ASC) and **Birthing Center Services**

ASC Limitations

Services are limited to those surgical procedures which are covered by Medicare and which have been identified by HHS pursuant to 42 CFR 416.60-75, and to those surgical procedures deemed cost effective by the Department.

Services are provided by distinct entities that operate exclusively for the purpose of providing surgical services to eligible recipients not requiring hospitalization.

Services are furnished to outpatients.

Services are furnished by facilities that meet requirements in 42 CFR 416.25 through 416.49.

Ambulatory surgical centers are recognized by state law under OCGA Section 31-7-1(1)(D).

Birthing Center Limitations

The birthing center delivery services are limited to women for whom it is medically appropriate, i.e. women who meet the definition contained in the Rules of the Georgia Department of Human Resources --- Physical Health, under chapter 290-5-41-07.

TRANSMITTAL 90-37
APPROVED 4/24/91
EFFECTIVE 10/1/90
SUPERSEDES (NEW)

10a. ADULT DENTAL SERVICES

Limitations

Dental services are available to recipients age 21 and over. Covered procedures include only those described below:

Diagnostic radiographs: Panoramic and individual periapicals.

Emergency examinations during office hours and after hours emergency examinations.

Oral and maxillofacial surgery services.

Anesthesia including nitrous oxide, intravenous sedation and general anesthesia.

Hospital admissions, inpatient and outpatient, when prior approved.

Post-Treatment Claim Review:

Claims for covered services exceeding $600.00 per recipient per provider, per calendar year must be submitted to the Department for post-treatment review.

Prior Approval is required for those surgical procedures described in the Policies and Procedures for Oral Maxillofacial Surgery Dental Services manual, Part II.

10b. EPSDT DENTAL

All medically necessary dental services will be provided to all recipients under age 21 when these services are provided at intervals that meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved with child health care, and at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition.

Prior Approval is required for the following dental services:

Plan of care exceeding $600.00 per recipient, per provider, per calendar year. Services totaling less than $600.00 do not require prior approval unless they cause the Total amount to exceed $600.00. Emergency services are exempt from prior approval but must be submitted for post-treatment review.

Hospital admissions, inpatient and outpatient.

Root canal therapy.

Anesthesia including nitrous oxide, intravenous sedation and general anesthesia.

Chemotherapy , therapeutic.

Other drugs and medicants.

More than two denture adjustments, one laboratory relining, or two tissue conditionings per recipient, per calendar year.

Catastrophic procedures, except emergency treatment.

Orthodontic treatment.

Dentures.

Management of difficult children.

Space management therapy.

Hospital time/consultation.

Periodontal Services.

Pulp cap (Indirect)

Special surgical procedures as discussed in Part II of the Policies and Procedures for Oral Maxillofacial Surgery Dental Services manual.

11. a.b.c. THERAPY SERVICES (Physical, Occupational and Speech Pathology)

Limitations:

1. Physical Therapy, Occupational Therapy and Speech Pathology services are limited to:

   - Recipients under the age of 21 years.
   - Services included in a written treatment plan established by a Georgia licensed physician.
   - Medically necessary services.

2. Providers must meet the qualifications specified in 42 CFR 440.110 applicable to each type of therapy provided.

   Providers must also be currently licensed by their respective Boards as follows:

   a. Occupational Therapists licensed by the Georgia State Board of Occupational Therapy.

   b. Physical Therapists licensed by the Georgia State Board of Physical Therapy.

   c. Speech Pathology Therapists licensed by the Georgia State Board of Examiners for Speech-Language Pathology and Audiology.

3. For enrollment or re-enrollment beginning July 1, 1994 providers stated above must receive four (4) contact hours of pediatric training or experience.

   All medically necessary occupational therapy, speech pathology therapy and physical therapy services will be provided to all EPSDT eligible recipients whether or not such services are covered or exceed the benefit limitations in the program if medical necessity is properly documented and prior approval is obtained.

TRANSMITTAL 93-044
APPROVED 3-11-94
EFFECTIVE 7-1-93
SUPERSEDES New

11. a.b.c. THERAPY SERVICES (Continued)

Prior Approval

a. Physical Therapy: More than ten hours per month.

b. Occupational Therapy: More than ten sessions per month.

c. Speech Pathology Therapy: More than ten sessions per month.

Non-Covered Services

- services associated for vocational or employment purposes
- services that do not require a licensed therapist
- services provided for temporary disabilities which would reasonably be expected to improve spontaneously as the patient gradually resumes normal activities
- preventive health care
- biofeedback
- physical therapy, occupational therapy or speech pathology therapy services provided in an in-patient hospital, outpatient hospital or nursing facility
- physical therapy, occupational therapy or speech pathology therapy services in the home if the services are available and provided through Home Health or Waivered Home Care Services programs
- services provided in a state-owned facility, and experimental services, investigational procedures or those procedures which are not recognized by the profession or the United States Public Health Service as universally accepted treatments.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Dentures.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

c. Prosthetic devices.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

d. Eyeglasses.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

*Description provided on attachment.

12a. **PRESCRIBED DRUGS**

Limitations

All medically necessary pharmacy services will be provided to recipients under age 21 when these services are provided within the laws and regulations governing the practice of pharmacy by the State.

Effective November 1, 1991 the Department will pay for no more than six (6) prescriptions, new or refills, per recipient under 21 years of age and no more than five (5) prescriptions, new or refills, per recipient over 21 years of age per calendar month unless an exception has been obtained to exceed the limit, or the physician documents that the prescriptions was for an emergency.

Covered Services

Drugs for which Medical Assistance reimbursement is available are limited to the following:

Covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under Section 1927(a) of the Act which are prescribed for a medically accepted indication.

As provided by Section 1927(d) of the Act, certain outpatient drugs may be excluded from coverage. Those excluded are:

(1) agents used for anorexia or weight gain;
(2) agents used to promote fertility;
(3) agents used to promote smoking cessation;
(4) agents used for cosmetic purposes or hair growth;
(5) barbiturates, except Phenobarbital and Secobarbital;
(6) nonprescription drugs with the following exceptions: enteric coated aspirin, meclizine, iron, multivitamins, insulin and diphenhydramine;
(7) prescription vitamins and mineral products, except prenatal vitamins and flouride products that are not in combination with other vitamins;
(8) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee;
(9) drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations (DESI drugs).
(10) Effective November 1, 1991, cough and cold medications will not be covered for recipients over 21 years of age. The Department defines cough and cold medications to be decongestants, antitussives and expectorants alone or in combination with each other. Antihistamines, when they are combined with one or more of the above products are also considered cough and cold preparations.

TRANSMITTAL 91-43
APPROVED 1-28-94
EFFECTIVE 11-1-91
SUPERSEDES 91-13

New drugs of participating manufacturers (except excluded/restricted drugs specified in Section 1927(d)(1)-(2) and listed above) will be covered without prior approval requirements for at least six (6) months after FDA approval and upon notification by the manufacturer of a new drug. Effective January 1, 1994, new drugs that have the same use or are in the same therapeutic category as products with therapy limitations or prior approval requirements will be placed under the same limitations or restrictions as the related drugs.

No payment will be made for innovator multiple source drugs for which federal upper limits have been established, unless the physician has certified the brand is medically necessary in his own handwriting on the prescription.

Prior Approval is required for recipients to obtain needed drugs in excess of the six (6) prescriptions per month limit and for certain types of drugs with therapy limitations (and for certain drugs prior to dispensing).

Effective July 1, 1991, prior authorization is provided through a contractual agreement within a twenty-four (24) hour turnaround from receipt of the request for drugs with limitations or which require prior approval before dispensing. The contractor is allowed a maximum of five working days to process requests to exceed the monthly prescription limit. Emergency prescriptions may be dispensed for up to a month's supply of medication.

Drug Rebate Agreement

- The state will comply with the reporting requirements for State utilization information and on restrictions to coverage.
- If the State has "existing" agreements, these will operate in conformance with law, and for new agreements, require HCFA approval. The State agrees to report rebates from separate agreements.
- The State will allow manufacturers to audit utilization data.
- The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

TRANSMITTAL 94-010
APPROVED 5-12-94
EFFECTIVE 1-1-94
SUPERSEDES 91-43

12.c. PROSTHETIC SERVICES

Prosthetic devices, including hearing aids, that are prescribed by a physician and are medically necessary for recipients under the age of 21 years are covered. For recipients 21 and over, prosthetic devices must be ordered or prescribed by a physician. Measurement and fitting must be performed by a practitioner who is certified in prosthetics.

Hearing aids for recipients under the age of 21 years are provided once every three years unless medically necessary and prior approved.

Non-Covered Services

Items which are not within the scope of definition of prosthetic devices.

Orthopedic shoes and supportive devices for the feet which are not an integral part of a leg brace are not covered for recipients 21 years of age and over.

Hearing aids and Accessories are not covered for recipients over 21 years of age.

TRANSMITTAL 91-46
APPROVED 1-28-92
EFFECTIVE 11-1-91
SUPERSEDES (NEW)